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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KENNETH D. CHAVEZ 43720 Elkhorn Trail Palm Desert, CA 92211 Registered Nurse License No. 595452 Respondent.	Case No. 2009-282 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 1, 2002, the Board of Registered Nursing issued Registered Nurse License Number 595452 to Kenneth D. Chavez (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2009, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a ____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

REGULATORY PROVISIONS

9. California Code of Regulations, title 16, section 1442 states:

As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

10. California Code of Regulations, title 16, section 1443 states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

11. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

12. California Code of Regulations, title 16, section 1444 states:

A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

(a) Assaultive or abusive conduct including, but not limited to, those violations listed in subdivision (d) of Penal Code Section 11160.

(b) Failure to comply with any mandatory reporting requirements.

(c) Theft, dishonesty, fraud, or deceit.

(d) Any conviction or act subject to an order of registration pursuant to Section 290 of the Penal Code.

COST RECOVERY

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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14. On June 18, 2001, Respondent was employed as a Perinatal Technician by Eisenhower Medical Center ("EMC") in Rancho Mirage, California. On March 8, 2002, Respondent obtained a Registered Nurse position with EMC. On February 4, 2004, following allegations of mishandling controlled substances, Respondent resigned his position with EMC.

15. Pyxis MedStation ("Pyxis") is an automated single-dose medication dispensing system that records information such as the patient's name, physician orders, date and time the medication was withdrawn, and the name of the licensed individual who withdrew the medication. Leftover or unadministered medication must be recorded as wastage in Pyxis. The total amount of medication withdrawn from Pyxis should balance with the charted amount administered to the patient in the patient's Medication Administration Record (MAR), and any amount of leftover medication that was wasted. A witness to the wastage must provide their identification number to verify the controlled substance was in fact wasted.

16. A Patient-Controlled Analgesia (PCA) is a drug-delivery system that dispenses a preset intravascular dose of a narcotic analgesic when the patient pushes a switch on an electric cord. The device consists of a computerized pump with a chamber containing the drug. The patient administers a dose of narcotic when the need for pain relief arises. A lockout interval automatically inactivates the system if a patient tries to increase the amount of narcotic within a preset period.

17. Dilaudid, a brand name for hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(K) and is a dangerous drug pursuant to Business and Professions Code section 4022.

18. As a result of a complaint filed with the Board by Eisenhower's Chief Nursing Officer on or about February 23, 2004, the Division of Investigation (DOI) was directed to conduct an investigation which revealed the following facts:

19. On December 2, 2003, Patient CM had a physician's orders for 6 mg. of Dilaudid to be administered intravenously every 4 hours as needed for pain. The physician's order changed at 0100 on December 3, 2003 to 6 mg. of Dilaudid intravenously every 3 hours as needed for pain. At 0930 on December 3, 2003, the order was amended to repeat the Dilaudid dose, then resume prior schedule (every 4 hours). Respondent administered Dilaudid to Patient CM more frequently than ordered by the physician and in amounts less than ordered by the physician. There were no nursing notes prepared by Respondent for this patient. Pyxis recorded a pattern of large withdrawals and wastage of Dilaudid as follows:

Patient CM - Dilaudid Activity for December 3, 2003

Time & Amount Withdrawn	Amount Administered	Amount Wasted	Recorded on MAR	Unaccounted for in Records
0729: 2 x 4 mg (8 mg)	3 mg	0	3 mg @ 0730	5 mg
0830: 2 x 4 mg (8 mg)	3 mg	5 mg	3 mg @ 0900	
0940: 2 x 4 mg (8 mg)	4 mg	4 mg	4 mg @ 1000	
1058: 4 x 2 mg (8 mg)	4 mg	4 mg	4 mg @ 1145	
1259: 4 x 2 mg (8 mg)	4 mg	4 mg	4 mg @ 1400	
1421: 2 x 4 mg (8 mg)	2 mg	0	Not recorded	8 mg
1454: 2 x 4 mg (8 mg)	2 mg	6 mg	2 mg @ 1500	
1631: 4 x 2 mg (8 mg)	4 mg	4 mg	Not recorded	
			Total	**13 mg**

20. *On or about December 22, 2003, the unit's Clinical Director prepared a* letter of counseling to Respondent. The letter outlined Respondent's performance deficiencies including not completing his charting, not conducting charting reviews including medication checks, not properly assessing his patients, I.V. fluids not being changed when running low, taking sodas from the patients' refrigerators, not completing intakes and outputs by the end of the shift, and characterized Respondent's work as "sloppy."

21. Pyxis reports showed that for Patient AC, Respondent had the same pattern of large withdrawals of Dilaudid, followed by a large amount of wastage relative to the amount administered to the patient. Respondent's entries regarding the Dilaudid were unintelligible (e.g. signed out 4 mg Dilaudid, administered 3 mg., and wasted 5 mg.)

Patient AC - Dilaudid Activity for January 25, 2004

Time & Amount Withdrawn	Amount Administered	Amount Wasted
1116: 2 x 2 mg (4 mg)	2 mg	2 mg
1141: 3 x 2 mg (6 mg)	3 mg	3 mg
1241: 1 x 4 mg	2 mg	2 mg
1446: 3 x 2 mg (6 mg)	2 mg	4 mg
1853: 2 x 4 mg (8 mg)	3 mg	5 mg

Patient AC - Dilaudid Activity for January 26, 2004

Time & Amount Withdrawn	Amount Administered	Amount Wasted
0743: 2 x 4 mg (8 mg)	4 mg	4 mg
0821: 2 x 4 mg (8 mg)	4 mg	4 mg
0936: 4 x 2 mg (8 mg)	No amount recorded administered or wasted	
1815: 3 x 2 mg (6 mg)	2 mg	4 mg

22. According to the Pyxis records, on January 31, 2004 at 2:11 p.m., Respondent removed a 50 mg syringe of Dilaudid as an "override" meaning there was no patient or physician's order. Respondent was not scheduled for work that day and time cards did not reflect that Respondent had clocked in. According to Respondent, he came to work that day to return a pair of earrings to a coworker. The coworker was not there, so instead of locking the earrings in a locker at the nurse's station for safe-keeping, Respondent stated in a letter that to the DOI investigator he opened Pyxis as an "override" for a 50 mg syringe of Dilaudid, then decided to place the earrings in the unit's lockbox instead. An inventory showed that 50 mg. of Dilaudid for a PCA pump could not be accounted for in any hospital records.

23. With regards to patient LG, on or about February 1, 2004, one hour before his shift was due to start at 0700, Pyxis records showed that Respondent performed a "cancel-remove" override for a 50cc syringe of Dilaudid. Respondent claimed he dropped the 50cc syringe of Dilaudid while attempting to insert it into a PCA; it was too damaged to be used and was wasted. The canceled Dilaudid removals for Patient LG were executed before the attending physician made the order for Dilaudid.

24. In an interview with the DOI investigator, the Clinical Director and Respondent's former RN supervisor explained that a 50cc syringe of Dilaudid for a PCA is one unit; it is removed from Pyxis and placed in the locked PCA pump machine. The 50cc syringe is plastic and nearly indestructible. Additionally, it was considered very unusual for a patient would use more than 50 mg. of Dilaudid from a PCA in a 24-hour period.

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25. Records show that Respondent frequently signed out doses of Dilaudid, then immediately canceled or overrode the removal.

26. On or about February 4, 2004, after being confronted at EMC about the missing Dilaudid, Respondent denied the charges, resigned his position, and immediately left the hospital.

27. In DOI interviews with some of Respondent's former coworkers at EMC in September 2005, the consensus was that Respondent showed an inordinate interest in tending to patients who had orders for Dilaudid PRN (as needed for pain). If his patients did not have the order in their chart, Respondent would recommend to the attending physician to order Dilaudid. Respondent also had the reputation of receiving lots of overtime hours but would never finish his charting or laboratory requests, instead leaving them for the next shift to complete. One coworker who worked closely with Respondent stated that she believed Respondent worked at EMC while under the influence.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence & Incompetence)

28. Respondent has subjected his license to disciplinary action under section 2761, subdivision (a)(1) of the Code, in that Respondent, while an employee of Eisenhower Medical Center, exhibited an extreme departure from the standard of care as detailed in paragraphs 18-26, above, and incorporated herein by reference. Respondent, on numerous occasions, failed to properly chart medications or made unintelligible entries in the patients' MAR, administered Dilaudid to patients more frequently than ordered by the physician in amounts less than ordered by the physician, did not properly assess his patients, did not change I.V. fluids when they were running low, and exhibited an ongoing pattern of withdrawing large amounts of Dilaudid, then canceling or overriding the withdrawal.

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SECOND CAUSE FOR DISCIPLINE

(Possession of a Controlled Substance)

29. Respondent is subject to disciplinary action under section 2762, subdivision (a) in that Respondent, on or about December 3, 2003 and January 31, 2004, illegally obtained and/or possessed Dilaudid, a controlled substance and dangerous drug, stolen from his employer using subterfuge and diversion as detailed in paragraphs 19-26, above. Said unprofessional conduct is substantially related to the qualifications, functions and duties of a registered nurse pursuant to California Code of Regulations, title 16, section 1444, subdivision (c).

THIRD CAUSE FOR DISCIPLINE

(Falsify or Make Grossly Inconsistent/Unintelligible Entries in Patients' Records Pertaining to Controlled Substances)

30. Respondent is subject to disciplinary action under section 2762, subdivision (c) in that Respondent made false and/or grossly inconsistent or incorrect entries for controlled substances in a the patient records at Eisenhower Medical Center as detailed in paragraphs 19-27, above. Said unprofessional conduct is substantially related to the qualifications, functions or duties of a registered nurse and evidences the present or potential unfitness of Respondent to practice in a manner consistent with the public health, safety, and welfare.

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31. Respondent was employed by John F. Kennedy Memorial Center (JFK) in Indio, California from February 18, 2004 until he was terminated on August 6, 2005 for failing to account for controlled substances, improper charting, failing to follow standards of practice, and poor clinical performance.

32. SureMed Automated Distribution System ("SureMed") is an automated single-dose medication dispensing system, similar to Pyxis, that records information such as the patient's name, physician orders, date and time the medication was withdrawn, and the name of the licensed individual who withdrew the medication. Leftover or unadministered medication must be recorded as wastage in SureMed. The total amount of medication withdrawn from SureMed should balance with the charted amount administered to the patient in the patient's

Medication Administration Record (MAR), and any amount of leftover medication that was wasted. A witness to the wastage must provide their identification number to verify the controlled substance was in fact wasted.

33. Dilaudid, a brand name for hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(K) and is a dangerous drug pursuant to Business and Professions Code section 4022.

34. Demerol, a brand name for meperedine hydrochloride, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b), and is a dangerous drug pursuant to Business and Professions Code section 4022.

35. Morphine sulfate is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and is a dangerous drug pursuant to Business and Professions Code section 4022.

36. As a result of a complaint filed with the Board by JFK's Chief Nursing Officer on or about October 21, 2005, the Division of Investigation (DOI) was directed to conduct an investigation which revealed the following facts:

37. Patient A: According to a JFK Incident/Occurrence Reporting Form dated September 16, 2004, Respondent ran Patient A's intravenous (IV) medication all night long knowing that she was a dialysis patient. When the day shift nurse asked how long the I.V. had been running, Respondent told his relief nurse, in the presence of the patient, that it had been running only 15 minutes.

38. **Patient B:** According to a JFK Incident/Occurrence Reporting Form dated October 5, 2004, Respondent failed to conduct a 24-hour check, and failed to check the medication sheets. Three drugs were listed on Patient B's MAR, but were not administered by Respondent.

39. **Patient C:** On or about January 28, 2005, Patient C was admitted at 1845 and assigned to Respondent. Respondent failed to conduct an admission assessment, his signature was illegible on the first page, and there were no signatures on the rest of the pages. In a subsequent review of medical conducted by Tenet (the parent company of JFK), Respondent was

admonished in a Performance Management Program Record of Conference dated March 14, 2005. Respondent was directed to pay attention to paperwork and review all charting for the shift before leaving. Respondent refused to sign the record of counseling and later claimed that he was never appraised of the counseling report.

40. **Patients D & E:** According to a JFK Incident/Occurrence Reporting Form dated February 18, 2005, prepared by Respondent, Respondent admitted that on Patients D and E, he failed to properly annotate their charts with regards to medications ordered.

41. **Patient F:** On April 6, 2005, Respondent was admonished in a memo that he failed to properly document the administration of blood products to Patient F..

42. Patient G: In a typewritten variance letter addressed to Respondent, Respondent's charting for Patient G on June 8, 2005 was reviewed and the following variances were found:

Admitting (Nursing) Paperwork:

- Initial assessment blank; no screenings done
- No physical assessment done
- No care plan started on admission
- No education assessment done on admission

Physician Orders:

- 6/4/05 order for Dilaudid: no time, date, no read back and verify documentation
- 6/4/05: Dilaudid written as a range order
- No order written for the K Rider that was ordered

Critical Lab Values:

- K+ 24 - No documentation that MD was informed of the critical lab value
- No documentation that the physician repeated back the lab value to the nurse
- Lab print out indicates that the Monitor Tech was informed of the critical lab value, not the nurse

Nursing Outcome Charting:

- Illegible
- MAR (initial sheet) not dated
- Patient problems not identified
- Patient problems not prioritized

In a DOI interview with Respondent, Respondent claimed he was never made aware of the variance letter.

43. **Patient H**: In a review of medical records conducted by Tenet/JFK, Respondent was admonished in a Performance Management Program Record of Conference dated June 10, 2005, for incomplete admission charting, and illegible writing and signatures. Patient H's attending physician complained that ordered pain medications were not justified and that Respondent failed to enter the medications into Patient H's chart as a phone order. Respondent refused to sign the counseling memo and said he was going to file a grievance with the union.

44. **Patient I**: In a memorandum dated August 8, 2005, it was reported to the Chief Nursing Officer that there were concerns regarding Respondent's care of Patient I. A nurse reported that upon relieving Respondent for the day shift, Patient I seemed to be over-medicated. The patient had not received narcotics prior to that night and was very sleepy. Patient I was due to go into surgery that morning, but Respondent left his shift without conducting any of the required pre-operative work. The patient was not kept N.P.O. (nothing by mouth), so surgery was delayed. Respondent did not chart Patient I during the night and did not sign the MAR. A review of the SureMed print-out for Patient I revealed that Respondent signed out for medications without physician orders. Respondent's off-going report was very brief; he left illegible notes with patient's information on the counter and told his relief: "I have to catch my ride, I can't stay any longer."

45. As a result of the discrepancies with Patient I, a SureMed print-out of narcotics administered by Respondent was obtained for the dates July 17 through July 24, 2005. Seven charts (A-F) were reviewed and the following discrepancies were noted:

Chart A: A post-operative patient received morphine sulfate as ordered, however, Respondent did not sign the MAR with his complete signature.

Chart B: Pain medications were given frequently but appropriately. Respondent did not sign the MAR.

Chart C: A long-term patient. Medications were only given at night and only by Respondent. There were no complaints of pain at any other time. SureMed showed that the

physician made a telephone order for Demerol at 2330 on July 15, 2005, however, Respondent's entries on the MAR indicate he medicated the patient at 2030 on July 14, 2005, twenty-seven hours before the Demerol was ordered for the patient.

Chart D:

- A physician's order dated July 17, 2005 was placed for Demerol 50 mg. IV (intravenous) Q4 (every four hours) PRN (as needed) for severe pain. At 0048 on July 17th, SureMed documented that Respondent withdrew 50 mg. of Demerol. The Nurse's Notes reflect that Respondent medicated this patient as per doctor's orders with Demerol 50 mg. Respondent wrote in the patient's MAR that the medication was administered at 0100, however, Respondent lined-out the entry indicating that the medication was not administered. There was no wastage indicated. Respondent failed to properly account for 50 mg. of Demerol.
- At 0307 on July 17th, Respondent withdrew 100 mg. of Demerol for this patient, two hours and 19 minutes after the last withdrawal, despite the fact that the doctor's orders were for every four hours. The patient's MAR reflected that Respondent administered the Demerol at 0300 on July 17th. The Nurse's Notes indicate that Respondent mistakenly removed 100 mg. Demerol instead of 50 mg. Demerol and he wasted the other 50 mg. Demerol without a witness. Respondent failed to account for 50 mg. of Demerol.
- At 0606 on July 17th, the SureMed report documented that Respondent withdrew another 50 mg. of Demerol for this patient, three hours and nine minutes since the last withdrawal. The MAR reflected that the patient was medicated at 0600, six minutes before the drug was withdrawn. The Nurse's Notes indicate the patient was medicated at 0700.
- The SureMed report documented that at 2118 on July 17th, Respondent withdrew 50 mg. of Demerol for the patient. The MAR indicated that the patient was medicated at 2115. The Nurse's Notes indicate the patient was medicated for pain, but did not specify which medication was administered.
- The SureMed report documented that at 0037 on July 18th, Respondent withdrew 50 mg. of Demerol for this patient. The MAR failed to reflect that Respondent

medicated the patient, and the Nurse's Notes did not indicate the patient was medicated. Respondent failed to account for 50 mg. of Demerol.

- At 0140 on July 18th, the SureMed report documented that Respondent withdrew 50 mg. of Demerol for the patient, one hour and three minutes after the last withdrawal (instead of the required four hours as ordered by the physician). The MAR and the Nurse's Notes both indicated that Respondent medicated the patient with Demerol at 0140.
- The SureMed report documented that Respondent withdrew 50 mg. of Demerol at 0504 on July 18th. The MAR reflected that Respondent medicated the patient at 0540, and the Nurse's Notes indicated that Respondent medicated the patient at 0515.
- The SureMed report documented that Respondent withdrew 50 mg. of Demerol for this patient at 2044 on July 18th. The patient's MAR reflected that Respondent administered 50 mg. of Demerol to the patient at 1930, 45 minutes before the recorded withdrawal. The Nurse's Notes indicate that at 1930, Respondent received a report from the day nurse that the patient's pain medications were being withheld due to low blood pressure. Respondent told the patient he would return to ascertain the patient's blood pressure. The Nurse's Notes reflect that the Demerol was administered at 2000. Respondent made an entry in the Nurse's Notes that he "will medicate when time with Demerol 50 mg."
- The SureMed report documented that Respondent withdrew 50 mg. of Demerol at 0008 on July 19th. The patient's MAR indicated that the medication was administered at 2300 on July 18th and the Nurse's Notes stated the Demerol was administered at 0005.
- The SureMed report recorded that Respondent withdrew 50 mg. of Demerol at 0245 on July 19th. The patient's MAR and the Nurse's Notes indicated the Demerol was administered at 0300.
- The SureMed report recorded that Respondent withdrew 50 mg. of Demerol at 0703 on July 19th. The patient's MAR indicated the medication was administered at 0630. There were no entries in the patient's Nurse's Notes after 0300.
- A new physician's order was entered at 2000 on July 19th for 2-3 mg. of

Dilaudid Q2 PRN (every 2 hours as needed for pain). SureMed documented that at 2037 Respondent withdrew two 2 mg syringes of Dilaudid for a total of 4 mg. The patient's MAR indicated Respondent administered an unknown amount of Dilaudid to the patient at 1930, nearly an hour before the recorded withdrawal. No wastage was recorded. Respondent either over-medicated the patient or failed to account for 1 mg. of Dilaudid.

- At 2149, Respondent withdrew two 2 mg. syringes of Dilaudid for a total of 4 mg. The MAR reflected that the medication was administered to the patient at 2145, however, the Nurse's Notes did not indicate the medication was administered and there was no wastage reported. Either Respondent over-medicated the patient or failed to account for 1 mg. of Dilaudid.

- At 0058 on July 20th, Respondent withdrew two 2 mg. syringes of Dilaudid

from SureMed for a total of 4 mg. Neither the MAR nor the Nurse's Notes indicate the medication was administered and no wastage was recorded. Respondent failed to account for 4 mg. of Dilaudid.

- The SureMed report documented that at 0244 on July 20th Respondent withdrew two 2 mg. syringes of Dilaudid for a total of 4 mg. The MAR reflected that 3 mg. of Dilaudid was administered at 0300, but the Nurse's Notes have no entry for this medication. Respondent failed to account for 1 mg. of Dilaudid.

- The SureMed report documented that at 0509 on July 20th Respondent withdrew 50 mg. of Demerol for the patient, even though the patient had complained of vomiting after the administration of Demerol.[1] The MAR reflected that Respondent administered the medication at 0500 and the Nurse's Notes reflected that Respondent administered the Demerol at 0500 for breakthrough pain.

- SureMed documented that at 0612 on July 20th Respondent withdrew two 2 mg. syringes of Dilaudid for a total of 4 mg. The patient's MAR has an entry lined out and

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1. Respondent contacted the attending physician to have Dilaudid prescribed to the patient.

circled indicating that the Demerol was not administered. The Nurse's Notes are illegible and there was no wastage recorded. Respondent failed to account for 4 mg. of Dilaudid.

- A physician's change order was entered at 0748 on July 20th for 1-2 mg. of Dilaudid every two hours as needed for pain. The SureMed report documented that at 1941, Respondent withdrew 2 mg. Dilaudid. The patient's MAR reflected that the patient was medicated at 1941, 1956, and 2024 with a total of 3 mg. Dilaudid. The Nurse's Notes reflect that the patient was medicated at 2000 with 1 mg. of Dilaudid. Respondent failed to account for 1 mg. of Dilaudid.

- The SureMed report documented that Respondent withdrew two mg. of Dilaudid for this patient at 2024 on July 21st. The MAR reflected an illegible entry at 2000 that the patient was medicated with Dilaudid, but the entry was crossed out. Respondent failed to account for 2 mg. of Dilaudid.

- The Nurse's Notes reflect that at 2127 on July 21st Respondent withdrew 2 mg. of Dilaudid for this patient. The patient's MAR reflected an illegible entry at 2000, but the entry was lined out. The Nurse's Notes did not record the administration of this medication. Respondent failed to account for 2 mg. of Dilaudid.

- The SureMed report recorded that at 2238 on July 21st Respondent withdrew two 2 mg. syringes of Dilaudid for this patient for a total of 4 mg. The patient's MAR did not reflect that the medication was administered. Respondent recorded in the Nurse's Notes that he administered 1 mg. of Dilaudid and that another nurse witnessed the wastage of this medication and the previous overage, however, this was not recorded in SureMed. Respondent failed to account for 1 mg. of Dilaudid. Further, this dose was withdrawn 1 hour 11 minutes after the last withdrawal (at 2127), in violation of the physician's order. Wastage was recorded three hours 21 minutes after the medication was withdrawn from SureMed.

- At 0210 on July 22nd, the SureMed report recorded that Respondent withdrew two 2 mg. syringes of Dilaudid for this patient, for a total of 4 mg. Respondent did not record the administration of the medication in the MAR. Respondent wrote in the Nurse's Notes at 0215 that the patient was sleeping with no complaint of pain, however, he recorded that he

medicated the patient as ordered at 0230. Respondent failed to properly account for 4 mg. of Dilaudid.

- The SureMed report documented that Respondent withdrew two 2 mg. syringes of Dilaudid at 0428 on July 22nd for a total of 4 mg. There was no wastage recorded. The MAR reflected that Nurse Irma administered the medication at 0400. In a 0445 entry in the Nurse's Notes, Respondent stated that "Irma called to start IV, Patient asking for more meds Irma to medicate." Respondent either failed to properly account for 4 mg. Dilaudid, or he violated nursing standards by allowing another nurse to administer medication signed out by Respondent.

- The SureMed report documented that at 0647 on July 22nd, Respondent withdrew a 2 mg. syringe of Dilaudid for this patient. No wastage was recorded. There was no record that the Dilaudid was administered in the MAR or the Nurse's Notes. Respondent failed to account for 2 mg. of Dilaudid.

Chart D reflects that Respondent failed to properly account for 150 mg. of Demerol and 26 mg. of Dilaudid over a one-week period.

Chart E

- Physician's orders dated July 22, 2005 at 2030 for morphine sulfate 2 mg. IV, Q1 pain, give dose now (2 mg. of morphine intravenously every 2 hours as needed for pain with the first dose to start at 2030). During Respondent's first 12-hour shift, he should have administered 24 mg. of morphine, however, SureMed documented that during Respondent's first 12-hour shift he withdrew 34 mg. of morphine sulfate, and during his second 12-hour shift he withdrew 38 mg. of morphine sulfate, a 63% increase over what the physician ordered.

- Additionally, Respondent entered that this was a telephone order. In an entry on the order Respondent wrote "7-22-05, 2130 Do not call me tonight on this patient T/O (telephone order Dr. G____ received by K Chavez." The physician later wrote on the order "I did not say that!"

- SureMed recorded that at 2003 on July 22nd, Respondent withdrew 4 mg. of morphine sulfate for this patient. No wastage was recorded. The MAR reflected that

Respondent administered 2 mg. of morphine at 2003. There is no record in the Nurse's Notes that the medication was administered. Respondent failed to account for 2 mg. of morphine sulfate.

- At 2029 on July 22nd, SureMed documented that Respondent withdrew another 4 mg. of morphine sulfate for this patient. Witnessed wastage was recorded for 2 mg. The patient's MAR reflected that the morphine was administered at 2030. The Nurse's Notes written by Respondent indicated that he received permission from Dr. G. to give an extra dose of morphine at that time. Respondent signed out for 4 mg. of morphine sulfate at 2247 with wastage of 2 mg. recorded. The MAR reflects that another nurse apparently administered the dose at approximately 2200, in violation of nursing regulations.

- At 2347 on July 22nd, SureMed documented that Respondent withdrew 4 mg. of morphine sulfate for this patient with a witnessed wastage of 2 mg. The MAR reflects the medication was administered at 2330, however there was an additional order for morphine sulfate written in the MAR reflecting wastage of 1 mg. There were no entries in the Nurse's Notes regarding the administration of these medications.

- At 0028 on July 23rd, SureMed documented that Respondent withdrew 4 mg. of morphine sulfate for this patient. There were no entries in either the patient's MAR or Nurse's Notes to reflect the administration of the medication. Respondent failed to properly account for 4 mg. of morphine sulfate.

- At 0140 on July 23rd, SureMed documented that Respondent withdrew 4 mg. of morphine sulfate for this patient with a witnessed wastage of 2 mg. at 0149. The MAR reflected the medication was administered at 0130 and the Nurse's Notes did not reflect what medication was being wasted.

- SureMed documented that on July 23rd at 0219, Respondent withdrew 4 mg. of morphine sulfate. No wastage was recorded. The patient's MAR reflected the morphine was administered at 0230. The Nurse's Notes failed to reflect the medication was administered. Respondent failed to properly account for 2 mg. of morphine sulfate.

- At 0404 on July 23rd, Respondent withdrew 4 mg. of morphine sulfate

from SureMed. No wastage was recorded. The patient's MAR failed to reflect that the morphine was administered, however, another nurse noted the administration at 0545. Respondent's entry in the Nurse's Notes at 0515 stated "Julie to medicate patient." Respondent failed to account for 4 mg. of morphine sulfate.

- SureMed documented that at 0612 on July 23rd, Respondent withdrew 4 mg. morphine sulfate for this patient with no recorded wastage. The patient's MAR reflected that 2 mg. of morphine were administered at 0615. The Nurse's Notes failed to reflect the medication had been administered. Respondent failed to account for 2 mg. of morphine sulfate.
- SureMed documented that at 0714 on July 23rd, Respondent withdrew 4 mg. of morphine sulfate for this patient with 2 mg. recorded as wasted. The patient's MAR and Nurse's Notes failed to reflect the administration of the medications. Respondent failed to account for 4 mg. of morphine sulfate.
- At 1935 on July 23rd SureMed documented that Respondent withdrew 4 mg. of morphine sulfate for this patient with no wastage recorded. The patient's MAR reflected that the morphine was administered at 1930. Respondent entered into the Nurse's Notes that another nurse witnessed the withdrawal and wastage of the medications, however, there were no entries in SureMed. Respondent failed to account for 2 mg. of morphine sulfate.
- At 2207 on July 23rd SureMed documented that Respondent withdrew 4 mg. of morphine sulfate with a witnessed wastage of 2 mg. at 2229. The patient's MAR reflected that the medication was administered at 2230. The Nurse's Notes failed to document the administration of the medication.
- SureMed documented at 2315 on July 23rd, Respondent withdrew 4 mg. of morphine sulfate without recorded wastage. The patient's MAR failed to reflect the medication had been administered. Respondent made an entry in the Nurse's Notes that another nurse ("Helen") witnessed the wastage, however, there was no wastage documented in SureMed. Respondent failed to account for 4 mg. of morphine sulfate.
- At 0017 on July 24th Respondent withdrew 4 mg. of morphine sulfate from SureMed without recorded wastage. The patient's MAR reflected that the medication was

administered at "24" (midnight), however, the Nurse's Notes reflected that Respondent administered the morphine at 0030. Respondent failed to account for 2 mg. of morphine sulfate.

- SureMed documented that at 0107 on July 24th Respondent withdrew 4 mg. of morphine sulfate without wastage recorded. The patient's MAR and the Nurse's Notes failed to reflect the administration of the medication. Respondent failed to account for 4 mg. of morphine sulfate.

- At 0222 on July 24th, SureMed documented that Respondent withdrew 4 mg. of morphine sulfate for this patient with no wastage recorded. The patient's MAR reflected that 2 mg. of morphine was administered at "02" (2 a.m.), however, the administration was not recorded in the Nurse's Notes. Respondent failed to account for 2 mg. of morphine sulfate.

- SureMed documented that at 0310 on July 24th Respondent withdrew 4 mg. of morphine sulfate for this patient with a witnessed wastage of 2 mg. at 0312. The patient's MAR reflected that the medication was administered at "03", however there was no documentation in the Nurse's Notes that the medication had been administered.

- SureMed documented that Respondent withdrew 4 mg. of morphine sulfate at 0525 on July 24th without wastage recorded. The MAR reflected that 2 mg. of morphine was administered. There was no entry in the Nurse's Notes that the medication was administered. Respondent failed to account for 2 mg. of morphine sulfate.

- At 0711 on July 24th, SureMed documented that 10 mg. of morphine sulfate was withdrawn for this patient with 8 mg. recorded as wasted at 0711. The patient's MAR failed to reflect the medication was administered. Respondent made the following entry in the Nurse's Notes: "Pt medicated prior to leaving. Helen to witness pyxis machine out of Morphine 4 mg IV. All was in machine Morphine 10 mg. Helen witness removal and waste of Morphine 8 mg into sink." Respondent failed to account for 2 mg. of morphine sulfate.

After working two 12-hour shifts, Respondent failed to account for 36 mg. of morphine sulphate for this patient.

Chart F: This patient had a chronic disease and pain issues. Physician orders were for 2 mg. Dilaudid Q4 (every four hours) on July 15, 2005; 3 mg. Dilaudid Q3 on July 16, 2005; and 2

mg. Dilaudid Q4 on July 18, 2005.

- Respondent made a handwritten entry in the patient's MAR for July 15-July 16, 2005: "Dilaudid 1 mg. Q4 PRN"; the physician gave no such order for Dilaudid.
- SureMed documented that at 0254 on July 17th Respondent withdrew two 2 mg. syringes of Dilaudid for this patient with no recorded wastage. The patient's MAR reflected that Respondent administered 3 mg. of Dilaudid at 0330. The Nurse's Notes read: "medicated as ordered." Respondent failed to account for 1 mg. of Dilaudid.
- SureMed documented that Respondent withdrew two 2 mg. syringes of Dialudid, for a total of 4 mg. at 0514 on July 17th. There was no wastage recorded. The patient's MAR reflected that 3 mg. of Dilaudid was administered at 0600, but the entry was overwritten to reflect 0700. Respondent wrote in the Nurse's Notes at 0505: "medication pulled early accidentally pt _____ explained needs to wait until 0700 for next dose pt verb understanding." Respondent withdrew the medication two hours before he administered it then failed to account for 1 mg. Dilaudid.
- At 1921 on July 17th, SureMed documented that Respondent withdrew two 2 mg. syringes of Dilaudid for a total of 4 mg. No wastage was recorded. The patient's MAR reflected that 3 mg. of Dilaudid was administered at 1930. The Nurse's Notes state that "pt. medicated as ordered" at 1915. Respondent failed to account for 1 mg. of Dilaudid.
- At 2155 on July 17th, SureMed recorded that Respondent withdrew two 2 mg. syringes of Dilaudid for a total of 4 mg. There was no wastage recorded. The patient's MAR reflected that 3 mg. of Dilaudid were administered at 2230. The Nurse's Notes state that "pt medicated as ordered pt _____ crying out, numerous request pt unable to get comfortable pain meds giving her about 3 hours of relief . . ." Respondent failed to account for 1 mg. of Dilaudid.
- SureMed documented that at 0113 and at 0122 on July 18th Respondent withdrew a total of 4 mg. of Dialudid for this patient. No wastage was recorded. The patient's MAR failed to reflect any medication was administered. The Nurse's Notes state that "comfort medications" were administered at 0100. Respondent failed to account for 4 mg. of Dilaudid.

- At 0331 on July 18th, SureMed documented that Respondent withdrew two 2 mg. syringes of Dilaudid for a total of 4 mg. No wastage was recorded. The patient's MAR reflected that at 0330 Respondent medicated the patient with 3 mg. of Dilaudid. The Nurse's Notes state at 0330 "Pt conts to call out c/o severe back pain . . ." Respondent failed to account for 1 mg. of Dilaudid.

- SureMed documented that at 0704 on July 18th, Respondent withdrew two 2 mg. syringes of Dilaudid for a total of 4 mg. for this patient. No wastage was recorded. The patient's MAR reflected that Respondent administered 3 mg. of Dilaudid. The Nurse's Notes state: "pt given Dilaudid as MD ordered for pain." Respondent failed to account for 1 mg. Dilaudid.

- At 1000 on July 18th the physician orders change to Dilaudid 2 mg IV Q4 PRN (Dilaudid 2 mg. intravenously every four hours as needed for pain). Respondent did not acknowledge the change until 2300, well into his night shift.

- At 1915 on July 18th, SureMed documented that Respondent withdrew two 2 mg. syringes of Dilaudid for a total of 4 mg. for this patient, twice what the physician ordered. No wastage was recorded. The patient's MAR reflected that at 1930, Respondent administered 2 mg. of Dilaudid. Respondent also annotated the MAR that the order for Dilaudid 3 mg Q2 had been discontinued. Respondent wrote "Dilaudid 1 mg. IV Q4 PRN." This was not an order from the physician. The Nurse's Notes indicate that the patient was "medicated as ordered." Respondent failed to account for 2 mg. of Dilaudid.

- SureMed documented that at 2322 on July 18th, Respondent withdrew 2 mg. of Dilaudid for this patient. The patient's MAR reflected that at 2330 Respondent administered 1 mg. of Dilaudid. The Nurse's Notes have a 2330 entry by Respondent: "medicated with Dilaudid 2 mg. IV." Respondent failed to account for 1 mg. Dialudid. Further, there was no physician order for 1 mg. of Dialudid.

- At 0115 on July 19th, SureMed documented that Respondent withdrew 2 mg. of Dilaudid for this patient. The patient's MAR reflected that 2 mg. of Dilaudid was administered at 0115. Respondent made a 0100 entry in the Nurse's Notes: "Ralph RN to

witness removal and waste of Dilaudid 1 mg into sink. Pt given Dilaudid 1 mg. IV push." The entries were unintelligible and the amounts of Dilaudid withdrawn, administered, and wasted did not add up correctly. There was never a physician order for 1 mg. Dilaudid; the orders were for 2 mg. of Dilaudid every four hours.

- At 0317 on July 19th, SureMed documented that Respondent withdrew 2 mg. of Dilaudid for this patient, two hours after the last withdrawal. No wastage was recorded. The patient's MAR reflected that Respondent administered 2 mg. of Dilaudid at 0317. The Nurse's Notes failed to indicate that the medication was administered.

- SureMed documented that at 0544 on July 19th Respondent withdrew 2 mg. of Dilaudid for the patient. No wastage was recorded. The patient's MAR reflected that Respondent administered 1 mg. of Dilaudid at 0700. Respondent recorded in the Nurse's Notes at 0630 that " . . .pt conts to c/o pain to back (low) pt given Dilaudid 1 mg IV Ralph to witness waste. Pain well controlled with Dilaudid 1 mg. IV. Will modify Dr sheet and also see about getting PO (by mouth) medication for pain." Respondent failed to account for 1 mg. of Dilaudid and withdrew the medication 1 hour and 16 minutes before it was administered.

- At 1937 on July 19th, SureMed documented that Respondent withdrew 2 mg. of Dilaudid for this patient. No wastage was recorded. The patient's MAR reflected that Respondent administered 2 mg. of Dilaudid at 1930. The Nurse's Notes indicate the patient was medicated at 2000.

- At 2335 on July 19th, SureMed documented that Respondent withdrew 2 mg. of Dilaudid for this patient, however, there was no indication in the Nursing Notes that the medication had been administered.

- At 0428 on July 20th, SureMed documented that Respondent withdrew 2 mg. of Dilaudid for this patient. The patient's MAR reflects that the medication was administered at 0400, however, the Nursing Notes do not reflect that any medication was administered.

Respondent failed to account for at least 13 mg. of Dilaudid during five 12-hour shifts.

46. After reviewing Charts A-F, the Chief Nursing Officer observed the following concerns and discrepancies:

a. There were multiple discrepancies in the narcotics reconciliation;

b. There were multiple discrepancies in MAR charting;

c. Respondent administered medications without a physician's order;

d. Respondent failed to communicate patient conditions and care needs to oncoming shift;

e. Respondent failed to prepare a patient for surgery;

f. Respondent was negligent with medication administration;

g. Respondent was negligent with patient documentation and assessment;

h. Respondent failed to follow hospital policy despite repeated reminders to clock and clock out.

47. The Chief Nursing Officer also documented in a memorandum dated August 8, 2005, that Respondent had been counseled numerous times regarding his performance deficiencies but refused to sign the counseling forms. Respondent was terminated.

48. In an interview with a DOI investigator on or about March 8, 2007, Respondent denied all charges of drug diversion, denied having been counseled about his nursing deficiencies, blamed former coworkers and supervisors for harassing him, and refused to submit to a urinalysis unless the pending criminal charges in Riverside Superior Court were dropped.

FOURTH CAUSE FOR DISCIPLINE

(Possession of a Controlled Substance)

49. Respondent is subject to disciplinary action under section 2762, subdivision (a) in that on and between July 17, 2005 and July 24, 2005, while employed at John F. Kennedy Memorial Center, Respondent possessed and/or obtained controlled substances by intentionally failing to properly account for the absence of 150 mg. of Demerol, 39 mg. of Dilaudid, and 36 mg. of morphine from three separate patients as described in paragraphs 44-47, above. Respondent subsequently refused to explain or justify the disappearance of the controlled substances. Said unprofessional conduct is substantially related to the qualifications, functions and duties of a registered nurse pursuant to California Code of Regulations, title 16, section

1444, subdivision (c).

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FIFTH CAUSE FOR DISCIPLINE

(Incompetence)

50. Respondent has subjected his license to disciplinary action under section 2761, subdivision (a)(1) of the Code, in that Respondent, while an employee of John F. Kennedy Memorial Center, regularly exhibited incompetence when he failed to failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in title 16, section 1443.5 of the California Code of Regulations. Further, Respondent ignored multiple counseling sessions and performance feedback that required Respondent to correct his deficiencies as described in paragraphs 44-47, above.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence)

51. Respondent has subjected his license to disciplinary action under section 2671, subdivision (a)(1) of the Code, in that Respondent, while an employee of John F. Kennedy Memorial Center, exhibited an extreme departure from the standard of care as described in paragraphs 44-47, above. Respondent repeatedly failed to provide nursing care as required and failed to provide care or to exercise ordinary precaution in multiple situations which Respondent knew, or should have known, jeopardized the patients' health or life, despite repeated warnings from his employer to correct his nursing deficiencies.

SEVENTH CAUSE FOR DISCIPLINE

(Falsify or Make Grossly Inconsistent/Unintelligible Entries in Patients' Records Pertaining to Controlled Substances)

52. Respondent is subject to disciplinary action under section 2762, subdivision (e) in that Respondent made false and/or grossly inconsistent or incorrect entries for controlled substances in a the patient records at John F. Kennedy Memorial Center, as described in paragraphs 44-47, above. Said unprofessional conduct is substantially related to the

qualifications, functions or duties of a registered nurse and evidences the present or potential unfitness of Respondent to practice in a manner consistent with the public health, safety, and welfare.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 595452, issued to Kenneth D. Chavez;

2. Ordering Kenneth D. Chavez to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/11/09

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant